Wyoming Department of Health

Commit to your health.

STATE OF WYOMING
MARGINAL DENTAL HEALTH PROGRAM

ELIGIBILITY:

Low-income families can submit an application to the Oral Health Program for their children, from birth to their nineteenth birthday. We require verification of income. An eligibility letter will be sent to families meeting our criteria. Children applying for the Marginal Dental Health Program cannot be covered by Wyoming Medicaid or Kid Care Chip.

Families can apply every year. All necessary treatments should be completed when they are eligible. Marginal Dental does cover sealants for these children.

BENEFITS:

This is a co-payment program. The Oral Health Program will pay for 85 percent of the provider's fees and the family will pay for the remaining 15 percent. The maximum amount per child is $1,000 when funds are available. The family is responsible for any balance over the maximum benefit amount.

For questions, or assistance with applying for the Marginal Dental Health Program, please contact the Oral Health Program at:

By Phone: (307)777-7945
By Fax: (307)777-8687
In Writing:
State of Wyoming
Department of Health
Oral Health Program
6101 Yellowstone Rd, Suite 420
Cheyenne, WY 82002

WE REQUIRE VERIFICATION OF INCOME. COPY OF LAST YEARS W-2 OR LAST PAY STUB OR SOCIAL SECURITY AND/OR RETIREMENT STATEMENT.

CONFIDENTIAL
APPLICATION FOR THE MARGINAL DENTAL HEALTH PROGRAM
Return Application to: State of Wyoming, Department of Health, Oral Health Program, 6101 Yellowstone Rd, Suite 420, Cheyenne, WY 82002

1. APPLICANT INFORMATION:

Patient's Name _____ Birthdate _____ Sex_____
Last First MI

Patient's Address_____
Street Address City County Zip Code

Name of Parent(s) or Legal Guardian_____

Address of Parent(s) or Legal Guardian_____

Number of Dependents in Home, Including Wage Earner(s) _____

2. PERSONAL INCOME:

FATHER OR GUARDIAN	MOTHER OR GUARDIAN
Occupation_____	Occupation_____
Date Employed_____	Date Employed_____
Employer_____	Employer_____
City_____	City_____
Total Monthly Earnings $_____	Total Monthly Earnings $_____
Social Security $_____	Social Security $_____
Income Tax $_____	Income Tax $_____
Insurance $_____	Insurance $_____
Other Deductions $_____	Other Deductions $_____
Monthly Take-Home Pay$_____	Monthly Take-Home Pay$_____
How many months a year are you employed?_____	How many months a year are you employed?_____
What was your TOTAL income last year? _____	What was your TOTAL income last year? _____

3. INSURANCE:

Do you have Health Insurance? _____ Health Insurance Company Name_____

Do you have Dental Insurance? _____ Dental Insurance Company Name_____

4. BUSINESS, FARM, OR OTHER INCOME:

	SOURCE	AMOUNT
A. Yearly farm or business income (if farm or business is shown please attach an itemized statement of business income and expenditures.)		
B. Monthly income from any source other than shown above (rental from property you own, dividends, social security, child support, welfare, unemployment, compensation, per capita payments, part-time/second job, etc.)		

5. DENTAL PROVIDER INFORMATION:

Please provide the name of your Dentist or Orthodontist of choice:

_____

Name Address City Zip Code

Please provide the name of your Public Health Nurse, School Nurse, Etc.:

_____

Name Address City Zip Code

6. FINANCIAL DATA:

MONTHLY EXPENSES

HOUSING:
Rent/Monthly Payments $_____

GROCERIES & HOUSEHOLD:
Supplies $_____
Clothing $_____
Electricity, $_____
Water, Gas
Transportation $_____
(Gas, Oil, Maint.)
Telephone $_____
Other (Specify) $_____
Insurance Premiums $_____
(other than those deducted from wages)
Life Insurance $_____
(per month)
Auto Insurance $_____
(per month)
Medical Insurance $_____
(per month)

MONTHLY PAYMENTS

TOTAL AMT PER MONTH

Medical (doctors, labs) $_____
Hospital _____
Dental _____
Automobile _____
Furniture _____
Appliances _____
Loans _____
Other (Specify) _____

OTHER ASSETS

1. Do you own your own home? Yes_____ No_____
   Estimated market value $_____
   Amount owed $_____
2. Do you own any other real estate? Y/N_____
   Estimated market value $_____
   Amount owed $_____
3. Do you have any stocks and/or bonds? Y/N_____
   Name & No. of stock/bond:_____
   _____
   Market value $_____
4. Where do you bank?_____
   Amt on deposit(checking)_____
   Amt on deposit(savings)_____
5. Do you own business or farm equipment?
   Yes_____ No_____
   Market value $_____
   Amount Owed $_____
6. Do you own livestock? Yes_____ No_____
   Market Value $_____
   Amount Owed $_____
7. Other assets (Specify): _____
   _____
   _____
   _____

Remarks:_____
_____
_____
_____
_____
_____
_____

Make and year of all vehicles _____	_____
_____	_____
	_____

7. Do you have other children receiving care from the Department of Health, Oral Health Program? _____

If so, give their complete names:_____

8. FAMILY CASE SHEET

This social summary will be used to assist in determining eligibility for Dental Services provided by the Oral Health Program. All information given is kept confidential.

Patient's Name:_____ DOB: _____
Address:_____
City, State, Zip Code:_____

ALL MEMBERS IN HOUSEHOLD—NOT INCLUDING PATIENT

Name: Last, First MI	Relationship to Patient	Birthdate (mm/dd/yy)	Place of Birth: City, State	Occupation/ School Grade

If there are more than one child applying for assistance under the Marginal Dental Health Program, please list names below:

_____ _____
Name: Last, First MI **DOB(mm/dd/yy)**

_____ _____
Name: Last, First MI **DOB(mm/dd/yy)**

_____ _____
Name: Last, First MI **DOB(mm/dd/yy)**

_____ _____
Name: Last, First MI **DOB(mm/dd/yy)**

I (we) apply for the care of _____ by the Department of Health, Oral Health Program. I am unable to pay for the recommended treatment. I will apply any hospital and/or dental insurance benefits I receive to the cost of my child's care. ALL INFORMATION I HAVE GIVEN ON THIS CONFIDENTIAL FINANCIAL STATEMENT AND APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Parent/Guardian Signature_____ Date_____